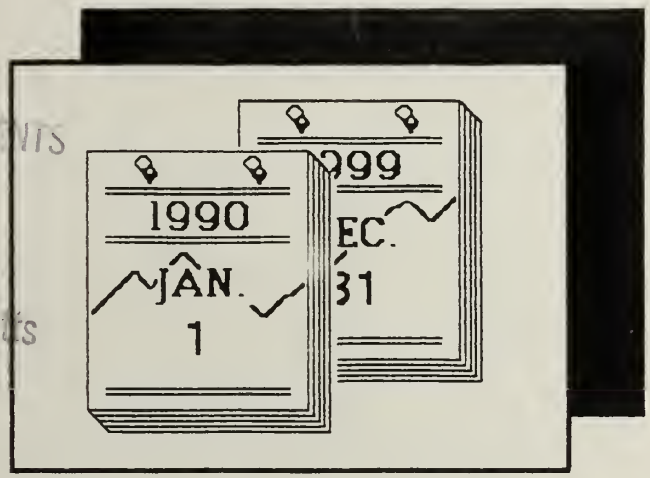
MASS. HS110.2:C73

UMASS/AMHERST
312066 0281 5810 9

Coming of Age: Can Community Health Centers Survive in the 1990's?

GOVERNMENT DOCUMENTS COLLECTION
JUN 12 1989
University of Massachusetts Depository Copy



Massachusetts Rate Setting Commission

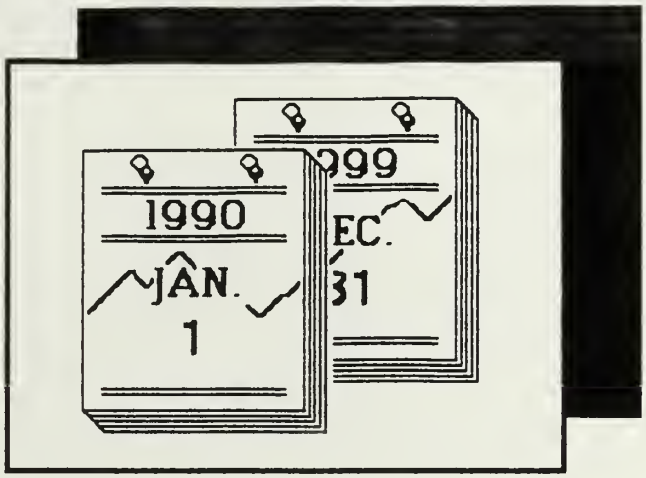
Paula Griswold, Chairman
Mary Yee Jong, Commissioner
Thomas K. Lynch, Commissioner

891/985

Michael S. Dukakis, Governor
Commonwealth of Massachusetts

Philip W. Johnston, Secretary
Executive Office of Human Services

Coming of Age: Can Community Health Centers Survive in the 1990's ?



Thomas S. Faiella, B.S.B.A. Susan E.W. Spencer, M.S.

Kristen Carlson-Lewis, M.P.H. Miriam L. Shark, Ph.D., M.P.A.

One of a series of reports on Community Health Facilities by the Bureau of Ambulatory Care

Copyright © January 1989 Massachusetts Rate Setting Commission

ACKNOWLEDGEMENTS

The authors are grateful to Martin McNamara and John Audette of the Massachusetts Rate Setting Commission for their assistance in compiling the data used in this report. Patricia Edraos, of the Massachusetts League of Community Health Centers, offered valuable guidance in suggesting areas of inquiry. Rate Setting Commission Chairman Paula Griswold, Commissioner Mary Yee Jong and Commissioner Thomas K. Lynch provided support and commitment to analyzing this critical component of the Massachusetts health care system. Harry O. Lohr, Jr., Director of Communications at the Rate Setting Commission, is to be thanked for his creative production assistance.

EXECUTIVE SUMMARY

Community health centers (CHCs) were once envisioned to fulfill the promise of accessible primary care in local neighborhoods. The Massachusetts Rate Setting Commission has tracked cost, utilization and revenue data for CHCs over the past 12 years. Are CHCs financially capable of making it on their own in an era of increasing health care competition? Have CHCs become an uncompensated care dumping ground? This study analyzes the background and trends in CHC financial experience and discusses implications for health planners and CHC administrators.

METHODS

Cost report data from freestanding CHCs in Massachusetts were analyzed predominantly over the time period of fiscal year 1982 through fiscal year 1987. Specific analyses examined trends in expenses, revenues, grant funding, adjustments to gross revenue, profitability, productivity, utilization, unit costs, and the costs of alternative hospital outpatient departments as reported on hospital cost reports.

RESULTS

- Total annual visits per CHC have increased by 18 percent between 1982 and and 1987, and by 41.7 percent since 1976.

- Visits for primary medical services decreased by 4.3 percent per CHC since 1982, but increased by 30 percent between 1976 and 1987.

- While the proportion of total visits by Medicaid and Medicare patients remained constant during 1982-1987, visits by self-pay patients decreased in proportion by 6.5 percent and visits by Blue Cross/private insurance patients increased by 6.8 percent.

- The proportion of total charges billed to Medicaid increased by 2.8 percent in 1982-1987, charges to self-pay patients increased by 12.5 percent, charges to Medicare decreased in proportion by 10 percent, and charges to Blue Cross/private insurance patients decreased relatively by 5.2 percent. Charge

- mix may reflect price differences across payor sources as well as differences in intensity of services used.

- The average number of uncompensated care visits per center increased by 136 percent between 1982 and 1987.

- Total average unit costs increased by 24 percent in 1982-1987. Medical unit costs rose by 36 percent. Support services' unit costs increased by 105 percent. Medical administrative unit costs increased by 17.3 percent. Except for the increase in support services' costs, these increases were below the rate of inflation in the Boston, Massachusetts area for this period.

- CHCs average total unit cost in 1987 was $60.51. This is 37 percent less that the total unit cost of two major municipal hospital outpatient departments.

- Federal grant funding, as a percent of total grant funding, decreased by 10 percent between 1983 and 1987. State grant funding picked up this share and more, as its share increased by 20 percent. Donated in-kind assistance decreased by 7 percent, and local government and private grants decreased by 2 percent and 1 percent respectively.

- In 1982, freestanding CHCs incurred a net loss of 15.7 percent of total expense. In 1987, the net loss was 2.3 percent, which relects in part the State's funding of uncompensated care, initiated in 1985.

TABLE OF CONTENTS

- ACKNOWLEDGEMENTS ii
- EXECUTIVE SUMMARY iii
- INTRODUCTION 1
- MASS. CHC UNCOMPENSATED CARE POOL 8
- MASS. HEALTH SECURITY ACT 10
- METHODS 12
- RESULTS 13
- DISCUSSION 17
- APPENDIX A: FIGURES 1—8B 20
- APPENDIX B: REFERENCES 31

I INTRODUCTION

Community health centers (CHCs) once known as neighborhood health centers, have been in existence for two decades. They have played an important role in offering primary care services to underserved communities. The question of how to keep these institutions financially viable has been a constant challenge since their inception. Current trends, such as the AIDS epidemic, continued access concerns, and documented cost savings provide an incentive to maintain these primary care sites. This study will address the historical development of community health centers, sources of financing, and an analysis of Massachusetts' experience with freestanding community health centers and its implications for their future viability.

BACKGROUND

The concept of community health centers, an outcome of the antipoverty programs in the Johnson era, began as an initiative to resolve health care access problems within medically underserved areas. The initial mandate of CHCs included the following: a focus on serving the "poor", provision of all services in one facility, participation of community residents, integration and coordination of existing community resources, assurance of personalized provision of quality care by qualified professionals, and obtaining the sponsorship of a number of public and private sources.[1] CHCs adopted a holistic approach to medical care, integrating the social, psychological and environmental factors surrounding low-income communities. Unique features of CHCs included outreach services, a team approach to care, social services, and community participation through employment and policy-making roles.[2] Initial expectations were that CHCs would be funded primarily through Medicare and Medicaid reimbursement grants.

The development and proliferation of CHCs has paralleled the prevailing political moods of federal and state government. As the following chronol-

---

[1] Elizabeth J. Anderson et al., The Neighborhood Health Center Program, Its Growth and Problems: An Introduction (Washington, D.C/: National Association of Neighborhood Health Centers, Inc., 1976), 12.

[2] Roger A. Reynolds, "Improving Access to Health Care Among the Poor - The Neighborhood Center Experience," Milbank Memorial Fund Quarterly/Health and Society 54(1): 47.

ogy illustrates, funding for CHCs rose with an increased political emphasis on social programs, and decreased in the face of budget deficits and retrenchment from social spending.

Under the auspices of the Office of Economic Opportunity (OEO), research and demonstration projects for development and funding of neighborhood health centers were initiated. These centers were an important extension of the Housing and Urban Development (HUD) Model Cities program. Renovation of facilities was financed through FHA loans by agreement of OEO, HEW, HUD, Bureau of Budget, and private mortgage and insurance companies. The scope of services of the health centers varied with the needs of individual communities as well as the extent of government funding sources.

By 1968, the Department of Health, Education, and Welfare (HEW) had joined the enterprise through provisions of the Comprehensive Health Planning and Public Health Service Amendments of 1966 (PL89-749) and the Partnership for Health Amendments of 1967 (PL90-174). Under Section 314(e), funds for CHCs in underserved areas contributed to the growth and development of these facilities across the United States. The HEW funding focused specifically on providing medical care, whereas earlier funds from OEO were targeted at community development in general.

Columbia Point Health Center in Boston's Columbia Point housing project was the first CHC approved by OEO in June 1965 and funded with $1 million of OEO research and development funds. The Center opened in December 1965. OEO was involved in the establishment of two other freestanding CHCs in the Boston area over the next five years, while three others were established under Boston's Model Cities Program in conjunction with HEW. Two other CHCs were established in Boston independently by HEW. Six CHCs were opened under the City's outreach program. By 1972, 19 CHCs existed in the Greater Boston metropolitan area.

By 1971, approximately 150 health centers nationwide were in operation, two-thirds sponsored by OEO and the remaining one-third under HEW.

At this time, the Nixon administration was advocating federal policies of financial self-sufficiency of health centers, transfer of authority from OEO to HEW, and regionalization of the administrative functions [3] The direction of the CHC program under HEW was much more narrowly defined and financial self-sufficiency a more pressing priority in the throes of cost-containment measures. With reductions in federal grant support, a new policy of third party reimbursement was advocated to allow for sliding fee scales and collection from third party payors Numerous health centers had difficulties implementing these initiatives resulting in severe program cuts, staff layoffs, and some closures.[4]

In 1974, the policy of self-sufficiency was reinforced and appropriations for fiscal year 1974 were cut by $5.1 million. Inflation and additional federal cutbacks resulted in further cuts in services and simultaneous increases in fees, which resulted in shifting the care of many impoverished back to hospital emergency rooms or outpatient departments. Federal political support for CHCs resurfaced, albeit minimally, in 1975. The Health Revenue Sharing and Health Service Act of 1975 included a provision for funding of CHCs for fiscal years 1976 and 1977, authorizing $10 million for development of new CHCs and $450 million for operating existing centers There was also a mandate in the Act to establish governing boards to replace consumer advocacy boards at CHCs. This provision reflected a continuing shift away from general community involvement and towards more accountable health services management.[6]

As of 1977, the federal government had funded development and operation of 420 centers seeing 3.3 million people at a cost of $225 million annually.[7] During this period in which CHCs were struggling to achieve fiscal solvency, a few competing activities were occurring. Believing that existing health

---

[3] Anderson, p 12 [4] Anderson, p.19

[5] Hal Strelnick, "Expanding Sutton's Law'" Health/PAC Bulletin, 12 (Nov./Dec., 1980), 23.

[6] Alice Sardell, "The Neighborhood Health Center: Model and Federal Policy," Health PAC Bulletin, 27

[7] Strelnick, 23

care institutions were part of the major block to provision of health care to the low-income population, the initial step of developing health centers was followed by an OEO initiative to reorganize hospital outpatient departments.[8] Second, many 314 (e) grants in the 1970s were usurped by Health Maintenance Organization (HMO) demon- stration projects, leaving decreased or level funding to health centers despite increased costs of medical supplies and services and an increase in patient utilization of CHCs. It was openly suggested at this time that many CHCs consider converting to HMOs.[9]

In addition, the American Medical Association had never fully supported the concept of neighborhood health centers, primarily because of the amount of federal intervention and the role of community policy-making. The AMA advocated termination of Section 314(e) funds to health centers and indirectly supported HEW's increasing productivity demands while decreasing the amount of federal grants and spreading them across more projects. This position has also been reflected in the difficulties recruiting and retaining physicians at CHCs.[10]

Financing Mechanisms

The basis for financial planning in 1965-6 was the introduction of Titles 18 and 19 of the Social Security Act, the Medicare and Medicaid programs. It was anticipated that 70 to 80 percent of costs would be recouped through government and third-party reimbursement, with the remaining sources being grants and the like, thereby ensuring fiscal solvency. In actuality, only 5 to 7 percent of health center revenues nationwide came from Medicare and Medicaid sources. On the state level, many Medicaid programs were establishing stricter eligibility requirements, reducing scopes of benefits, and decreasing reimbursement levels to providers.[11]

---

[8] Jude Thomas May, "The Professionalization of Neighborhood Health Centers," Health/PAC Bulletin, 12(2), 7.

[9] Anderson, p.17 and p.18.

[10] Reynolds, p.76-78, and Strelnick, p.23.

[11] Anderson, p.16 and p.17.

I INTRODUCTION

CHCs receive monies through two primary sources, grants and patient revenues. Grant money has come from a variety of sources as depicted in Exhibit 1 (see below).

EXHIBIT 1

SOURCES OF GRANT FUNDING

1. **'330' funding - an amendment of the 1975 Public Health Service Act (PL 94-63) consisting of grants for medically underserved areas, often subsidies for operation costs**
2. **Title Y of the Maternal and Child Health Mental Retardation Planning Amendments of 1963 of the Social Security Act - provides financial support and special projects to reduce maternal and infant mortality, decrease mental retardation, improve medical and dental health, usually payment for services of health care professionals**
3. **Women, Infants and Children program (WIC) of PL 92-433 (1972) - nutrition counseling and food**
4. **Title X of the Family Planning Services and Population Research Act of 1970 (PL 91-572) - provision of family planning services**
5. **Community Development Block grants under Title I of the Housing and Community Development Act of 1974 (PL 93-383) - consolidation of the Model Cities and urban renewal funds used for capital improvements and provision of services**
6. **National Institute of Mental Health (NIMH)**
7. **Community Employment and Training Act (CETA)**
8. **Title XX of the Social Security Act (PL 93-647) - funds to subsidize social services**
9. **National Institute on Alcohol and Alcoholic Abuse (NIAAA)**

Source: Young, Dale. A Promise Kept: Boston's Neighborhood Health Centers Boston: Trustees of Health and Hospitals, 1982.

In October 1985, The Commonwealth of Massachusetts established a program, subject to appropriation, which provided for the reimbursement of uncompensated care in freestanding CHCs. This legislation required that the

Massachusetts Rate Setting Commission establish through regulation criteria mandating that CHCs make reasonable efforts to collect payment for CHC services prior to attributing these services to uncompensated care. The level of assistance to each CHC is based on its previous fiscal year's uncompensated care experience. The allocation methodology is designed to encourage prudent credit and collection policies as well as limit the growth in reasonable costs through a cap on overall charges reimbursed through this initiative. A total of $2.9 million was distributed in fiscal years 1986 and 1987, and $1 million was distributed to CHCs in fiscal year 1988.

Ultimately, CHCs have survived so far both nationwide and in the Commonwealth. There still remains some willingness to support them through continued government financing and public entitlement although state government has taken over a larger burden from federal sources. Competition from for-profit ambulatory clinics, health maintenance organizations and preferred provider organizations have depleted patient insurance pools, thereby further aggravating CHCs' financial health.[12] Other factors affecting financial viability include the instability of grant funding, lack of access to capital, and cash flow limitations.

CHCs have reported success in meeting the needs of those in underserved communities by maintaining access and reducing costs.[13] Available evidence substantiates the positive impact of the health center on the community's health demonstrated by decrease in hospital utilization, both in length of stay and number of admissions.[14] Numerous studies reviewed by the Health Planning Council of Greater Boston also report these populations had increased access to care and improved health status at a lower cost when compared to other providers.[15]

---

12 Alonzo Plough, Holly Korda, and Thomas DelBanco, Boston at Risk - a report from the Boston Foundation Primary Health Care Seminar (September, 1985), 76.

13 Strelnick, p.25.

14 Anderson, p.73.

15 Plough, p.67.

I INTRODUCTION

Community health centers serve the community but can they meet a goal of self-sufficiency? Our study looks at financial trends in Massachusetts predominantly over a five-year span (1982-87) to determine the stability of revenues and costs of operation Also comparison of freestanding CHC costs to other alternatives (OPDs) may determine if CHCs are a good investment for society.

MASS. CHC UNCOMPENSATED CARE POOL

AUTHORITY

- Chapter 574, Sec. 12, of the Acts of 1985; added as M.G.L. c. 6A s. 76
- the original law expired September 1987, however, it was re-enacted by Section 19 of Chapter 23 of the Acts of 1988

HOW THE POOL WORKS

- subject to appropriation, the pool reimburses CHCs for 50 percent of allowable bad debt and 100 percent of allowable free care expenses
- Massachusetts Rate Setting Commission regulation 114.3 CMR 41.00 implements the provisions of the law, including eligibility standards, credit and collection policies, and fund allocation processes
- patient information is required at intake, including income and source of available payment
- free care standards include:
  - patients with income less than or equal to 100 percent of the Community Services Administration's poverty income guidelines must be exempt from collection action
  - patients with income less than or equal to 200 percent of the Community Service Administration's poverty income guidelines may be exempt from collection action
  - patients with income greater than 200 percent of the Community Services Administration's poverty income guidelines may be exempted due to medical hardship
- the maximum non-billable service payment collected at the time of encounter was, in fiscal years 1986-1988, $5.00, and is, in fiscal year 1989, $7.00

- CHCs must advise and assist patients concerning possible eligibility for public assistance programs

- five collection efforts within 180 days from the date of service must be made before an account may be deemed bad debt

The Impact Of The Uncompensated Care Pool On CHCs

- free care has increased as a percent of patient revenue, from a total of 1.29 percent in 1982 to 17 percent in 1987

- bad debt has been reduced as a percent of patient revenue, from a total of 4.39 percent in 1982 to 3.96 percent in 1987

- the uncompensated care pool accounts for a substantial portion of the increase in grant funding by the Commonwealth, from a total of 21 percent in 1983 to 41 percent in 1987

THE MASS. HEALTH SECURITY ACT CHAPTER 23 OF THE ACTS OF 1988

What The Law Does

- phases in insurance entitlement over 4 years, with all State funds subject to annual appropriation
- in 1988, makes available to 3,000 disabled children and adults supplemental Medicaid coverage
- establishes a Massachusetts Department of Medical Security to arrange insurance coverage for unemployed citizens
- from July to September 1989, makes small businesses eligible for partial tax credit if they initiate health insurance coverage for employees
- in 1991, makes health insurance available to workers receiving unemployment insurance
- in April 1992, requires all firms with 6 or more employees to pay $1,680/worker to a State fund; this payment would be reduced or eliminated by health insurance payments made by the employer
- in addition, the law addresses current hospital reimbursement methodology in Massachusetts

Potential Impact Of Chapter 23 On CHCs

- Chapter 23 could reduce the number of self-pay employed patients, thus strengthening the financial base of CHCs
- however, currently CHC patients eligible for free care have incomes below 100 percent of the poverty level; many are not employed; coverage for these individuals would improve only to the extent that they can obtain insurance through the Massachusetts Department of Medical Security

- if the Massachusetts Department of Medical Security develops a prepaid managed-care insurance program, then CHCs could serve as cost-effective, accessible, quality sites for primary care

METHODS

Since 1976 the Massachusetts Rate Setting Commission, which sets the state Medicaid and other state program rates for health services, has required freestanding community health centers to provide annual financial and statistical data. Beginning in 1979, these data have been provided through a standardized cost report, with the inclusion of certified financial statements. Required data include: balance sheet, statement of revenue, breakdown of restricted grant funding, statement of operating expenses, statement of basis of allocated costs, staffing information, and utilization information. These data are verified through desk audits and field reviews

Our analysis addresses only freestanding CHCs. We define freestanding CHCs as any licensed clinic which provides comprehensive ambulatory services and which is not financially or physically an integral part of a hospital. CHCs must also meet the conditions of participation of the governmental purchasers of CHC services or purchasers under the Workers' Compensation Act.

As a result of changes in licensure status and timeliness of report filing, the number of CHCs in our data base has varied from year to year. The fewest number (n=22) occurred in 1976, while the greatest number (n=32) was in 1983. Prior to 1982 CHCs were not required to report detailed bad debt or free care information, and several other data categories were constructed differently.

Our analysis is based primarily on the period between fiscal year ending June 30, 1982 and the fiscal year ending June 30, 1987. 1982 was the first year many critical data were reported consistently. Because the same number of CHCs did not report in every year in this period (e.g., in 1982 n=31, in 1987 n=28), the data were converted to percentages and averages to provide standardized comparisons of the industry across time

For the period between fiscal year 1982 and fiscal year 1987 we have analyzed expenses, revenues, grant funding, adjustments to gross revenue, profitability, productivity, total visits, medical visits, charges, unit costs, and the costs of alternative hospital outpatient departments as reported on the hospital cost reports collected by the Rate Setting Commission

RESULTS

ACCESS

The average number of visits for any service to freestanding CHCs in Massachusetts increased from 18,634 per CHC in 1976 to 26,412 in 1987, or by 41 7 percent. However, much of this increase occurred between 1976 and 1979 Since 1982, average total annual visits have increased by only 18 percent Visits dropped by 13 percent between 1979 and 1982, but rebounded by 1987 (see figure 1, page 21).

The average annual number of visits per CHC that were for medical services increased by a slighlty lower amount, from 11,082 per CHC in 1976 to 14,415 in 1987, or 30 percent. This number has actually decreased slightly between 1982 and 1987, during which a 4.3 percent decrease in average medical visits was found.

Despite the total increase in average medical visits, the average number of medical visits per Full Time Equivalent (FTE) medical employee in CHCs has dropped. In 1987 the average number of medical visits performed per FTE medical employee was 16.6 percent less than in 1982, and 29 percent less than in 1976 (see figure 2, page 22)

The proportion of total visits by patients covered by Medicaid and Medicare has remained constant between 1982 and 1987 (37% Medicaid and 7% Medicare). Visits by self-pay patients decreased from 42.8 percent to 36.3 percent of all visits during this time. This 6.5 percent relative decrease was offset by an equivalent increase in visits by Blue Cross/private insurance patients, whose share rose from 13 6 percent of all visits in 1982 to 20 4 percent in 1987 (see figure 3, page 23).

The proportion of CHC charges by payer category has shifted between 1982 and 1987 in a somewhat different pattern from visits. CHCs may have different rates which they charge different insurors. They also have sliding fee scales for self-pay patients. Changes may thus reflect price change, volume changes, or changes in mix of services performed. The proportion of charges billed to Medicaid, as a percent of all charges, increased from 37.7 percent in 1982 to 40.5 percent in 1987. Charges to self-pay patients also increased in proportion, from 21 5 percent in 1982 to 34 percent in 1987.

Medicare charges decreased from 17.4 percent to 7.5 percent, and Blue Cross/private insurance charges decreased from 23.3 percent to 18.1 percent (see figure 4, page 24).

The average number of visits recorded as uncompensated care increased by 136 percent between 1982 and 1987, from 2532 per CHC to 5969. The expense for uncompensated care visits as a percent of self-pay charges increased from 26.5 percent in 1982 to 62.3 percent in 1987.

Costs

Total average unit costs increased by 24 percent between 1982 and 1987, from $48.63 per visit to $60.51. During the same period, the CPI for all urban items in the Boston area increased by 21 percent (see figure 5, page 25).

Unit costs for medical services rose at a faster rate than total unit costs. In 1982 medical costs were $37.20 per visit and in 1987 they were $50.71, reflecting an increase of 36 percent. The medical care inflation index growth for Boston during that time was 49 percent. As a proportion of total costs, medical unit costs rose from 76 percent in 1982 to a total of 84 percent in 1987.

Unit costs for support services such as nutrition and social services increased by 105 percent, from $4.50 per unit in 1982 to $9.24 in 1987. Support service costs rose as a share of total costs from 9.3 percent to 15.3 percent.

Unit costs for medical administration increased only slightly, and decreased as a percent of total costs. In 1982 the unit cost for administration was $9.00, and in 1987 it was $10.56, a 17.3 percent increase. As a proportion of total costs, medical administration decreased from 18.5 percent in 1982 to 17.5 percent in 1987.

From a health care system perspective, the average total unit cost of CHCs in 1987 was much lower than the unit cost at two major municipal hospital outpatient departments. On average, each visit to a CHC saved 37 percent of the hospital OPDs' cost. CHCs' total unit cost was $60.51, compared to Boston

City Hospital's OPD unit cost of $84.54 and Worcester City Hospital's OPD unit cost of $180.89 (see figure 6, page 26)

Revenue

In 1982 patient service revenue accounted for 61 percent of total CHC revenue, restricted grants comprised another 20 percent, and unrestricted grants comprised 19 percent. In 1987 patient service revenue decreased to 58 percent of total revenue, restricted grants remained at 20 percent, and unrestricted grants increased to 22 percent (see figures 7a and 7b, pages 27, 28)

Not all patient service revenue, however, is actually realized by CHCs. In 1982, patient service revenue was adjusted by 1 percent for free care, 4 percent for bad debt, and 4 percent for contractual adjustments, leaving a net patient service revenue of 91 percent of its original account. By 1987, free care comprised 17 percent of patient revenue, bad debt remained at 4 percent, and contractual adjustments increased to 14 percent, leaving a net patient service revenue of only 65 percent of total patient charges (see figures 8a and 8b, pages 29, 30). Recently initiated State grants to fund uncompensated care are likely reflected in the sizeable increase in revenue accounted for as free care

Grant funding has always been an important source of CHC revenue, and in recent years it has become even more so. In 1982 restricted and unrestricted grants covered 35.2 percent of CHC general ledger expenses. In 1987 that amount had increased to 51.8 percent.

The period between 1983, when CHCs started reporting grants by their source, and 1987 saw a large decline in the proportion of CHC grants provided by the federal government and a corresponding increase in grants from the State (see Exhibit 2, page 16). In 1983, federal funding accounted for 38 percent of grants, which dropped to a 28 percent share in 1987. State funding increased from 21 percent of total grants in 1983 to 41 percent in 1987. Local funding remained fairly constant (18% to 16%), as did private grants (9% to 8%). Donated (in-kind) assistance dropped from 14 percent of total grants in 1983 to 7 percent in 1987. The State appears to have picked up this portion of assistance as well.

The Bottom Line: In 1982 freestanding CHCs incurred a net loss of 15.7 percent (net patient revenue as a percent of expense). Their fiscal health improved somewhat by 1987, when the net loss was 2.3 percent. It should be noted that in 1986 Massachusetts implemented a grant program to compensate CHCs for a portion of free care expense. However, this funding only underscores the degree to which CHCs must rely on grant support in order to survive.

EXHIBIT 2

GRANTS BY SOURCE, 1983-1987

Source	1983 Amount	1983 %	1987 Amount	1987 %
Total Grants	$ 16,776,000	100%	$ 23,120,969	100%
Federal	$ 6,397,000	38%	$ 6,467,287	28%
State	$ 3,602,000	21%	$ 9,582,317	41%
Local	$ 2,957,000	18%	$ 3,734,353	16%
Private	$ 1,539,000	9%	$ 1,792,146	8%
Donated	$ 2,281,000	14%	$ 1,544,866	7%

DISCUSSION

Community health centers in Massachusetts have succeeded in responding to the comprehensive health care needs of low-income or inner-city neighborhoods But their financial stability is shaky CHCs rely heavily on "soft money" such as grant funding, and government reimbursement which may fluctuate as budget constraints and policy shifts occur.

Although our data does not identify reasons for each visit, the 18 percent average growth in total visits since 1982 combined with a concurrent 4.3 percent decrease in medical visits suggests that CHCs are having to deal increasingly with the social and environmental problems of their communities, rather than strictly with traditional medical services. Nutrition, mental health, drug abuse education and family planning/parenting issues are among the many programs offered by CHCs to address special concerns of their clientele. Unfortunately, traditional third-party reimbursement, which pays for medical services, often does not cover the costs of these programs. The doubling of unit costs for these support services between 1982 and 1987 highlights the fiscally precarious nature of providing these important, but frequently underfunded, services.

A potential source for optimism is the trend towards increased visits among patients covered by Blue Cross or other private insurance, from 13.6 percent in 1982 to 20.4 percent in 1987. The concurrent proportional decrease in visits by self-pay patients would seem to reinforce this movement towards stronger financial ground. This shift in payer mix of visits may be due in part to increased HMO participation with CHCs or a potentially greater prevalence of health insurance benefits being offered by employers in a tight labor market Another explanation would be that in order to qualify for state funds for uncompensated care, CHCs are required to establish specific criteria for certain free-care eligibility standards and to counsel self-pay patients about the availability of potential third-party reimbursement sources.

However, while third-party reimbursed visits have increased in proportion, the trend in mix of charges by payer does not bode well. BlueCross/private insurance charges have decreased in proportion by 5.2 percent. This reduction may be attributable to special price discounts offered to HMOs and other private insurors, or to a less intensive (and expensive) mix of services used by these patients The 12.5 percent relative increase in self-pay

charges may reflect a higher morbidity and more intensive use of services among those who meet the new, more tightly defined criteria of "uninsured". Declines in productivity among medical personnel may also indicate a generally more intense caseload, or use of medical personnel for additional support functions. The 10 percent decrease in Medicare's share of charges may reflect cuts in federal reimbursement or an unusual decrease in intensity of services used by Medicare beneficiaries.

Uncompensated care has been a steadily increasing drain on CHCs' budgets. The average number of uncompensated-care visits has more than doubled between 1982 and 1987. The expense for uncompensated care visits has also risen from a quarter of self-pay charges to almost two-thirds. This trend may reflect more accurate accounting of uncompensated care for state grant purposes, or it may indicate a disturbing continuation of gaps in the health care insurance system. Full implementation by 1992 of the State's universal health insurance law (Chapter 23 of the Acts of 1988) should significantly reduce this prevalence of uncompensated care.

Massachusetts has picked up much of the uncompensated care burden through its grant program. Indeed, the State has taken over a significant share of funding that had formerly been provided by the federal government or through donated services. The presence of a payer mix which is heavily represented by self- pay and Medicaid, combined with a large decrease in federal support, would indicate that state funding plays a major role in keeping CHCs alive.

CHCs may not look like good investments to Wall Street, but they are cost-effective to the health care system. Not only are CHCs significantly less costly per visit than likely alternative sites of care, hospital OPDs, but their own growth in costs has not out-paced inflation. Medical care and administrative costs have in fact grown at a lower rate than inflation. Costs for support services are rising quickly, however, and CHCs must be alert to obtaining sufficient funds to cover these programs. In doing so, CHC administrators should become more fully aware of any restrictions and implications imposed by various funding sources. Community boards need to maintain their tradition of activism in voicing their concerns in the political and policy arenas.

DISCUSSION

Can CHCs meet both goals of serving the community and being financially self-sufficient? Past trends would indicate no. But CHCs are a good investment in the public health through their provision of cost-effective services to a high-need population. If CHCs are to survive, the public needs to strengthen its financial support.

APPENDIX A: FIGURES

Figure 1: Average Visits Per Center, 1976-1987 21

Figure 2: Medical Visits Per FTE, 1976-1987 22

Figure 3: Visit Mix By Payer, 1982-1987 23

Figure 4: Charge Mix By Payer, 1982-1987 24

Figure 5: Medical/Total Unit Costs, 1982-1987 25

Figure 6: Unit Costs/CHC vs. OPD, 1987 26

Figure 7a: Total Revenue, 1982 27

Figure 7b: Total Revenue, 1987 28

Figure 8a: Patient Service Revenue, 1982 29

Figure 8b: Patient Service Revenue, 1987 30

FIGURE 1

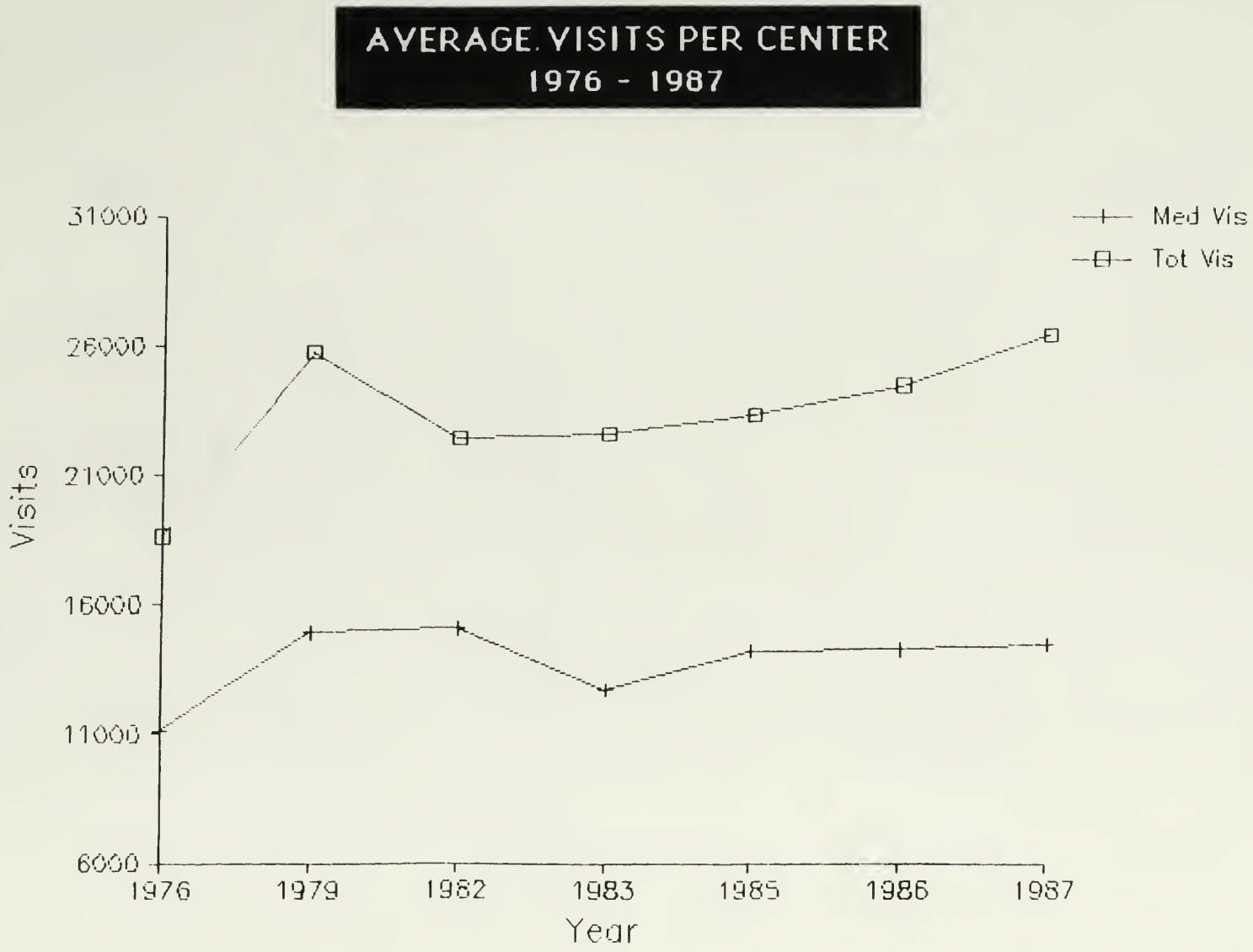

AVERAGE VISITS PER CENTER
1976 - 1987
Med Vis
Tot Vis
31000
26000
21000
16000
11000
6000
Visits
1976
1979
1982
1983
1985
1986
1987
Year

FIGURE 2

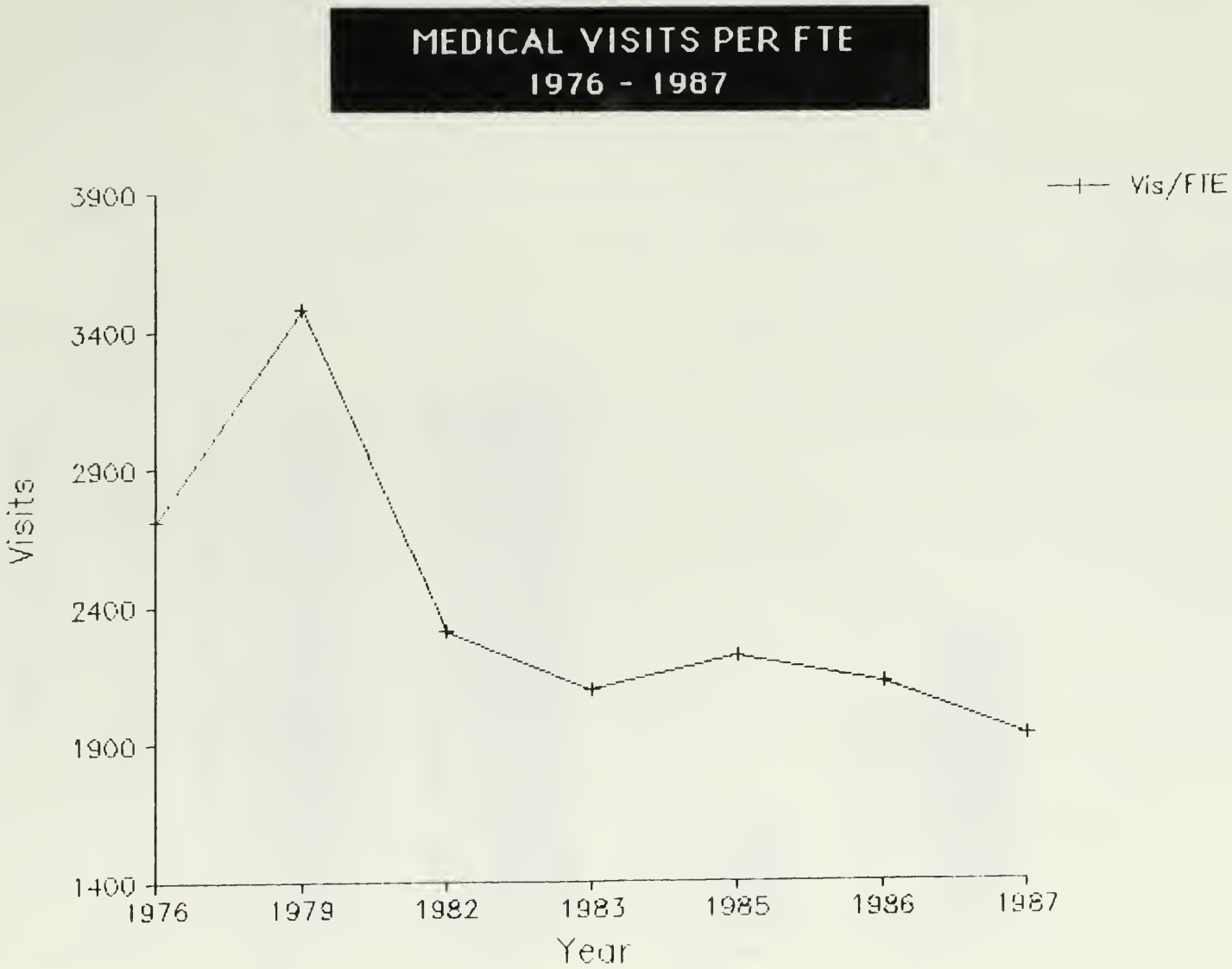

MEDICAL VISITS PER FTE
1976 - 1987
Vis/FTE
3900
3400
2900
2400
1900
1400
Visits
1976
1979
1982
1983
1985
1986
1987
Year

FIGURE 3

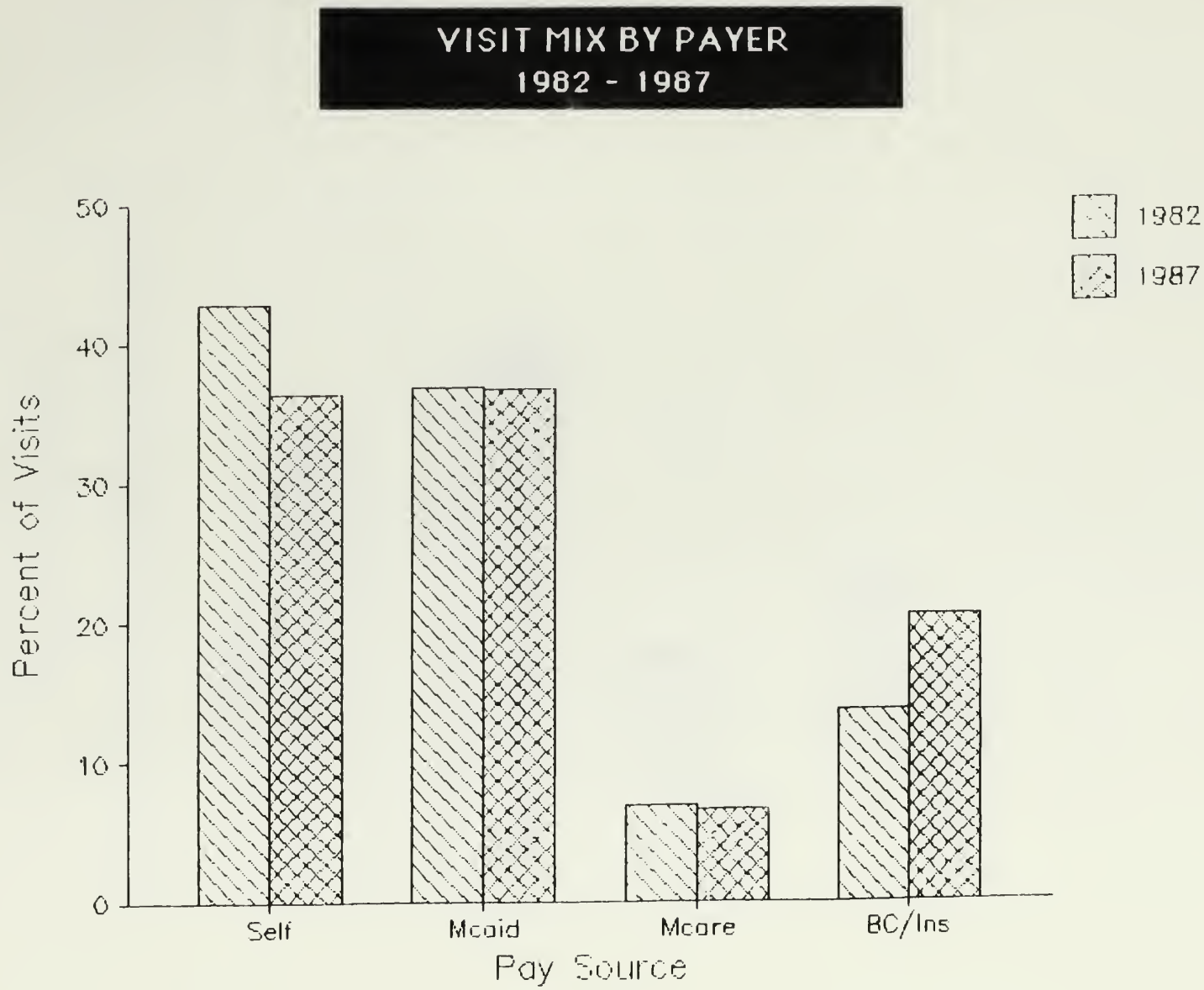

VISIT MIX BY PAYER
1982 - 1987
1982
1987
Percent of Visits
50
40
30
20
10
0
Self
Mcaid
Mcare
BC/Ins
Pay Source

FIGURE 4

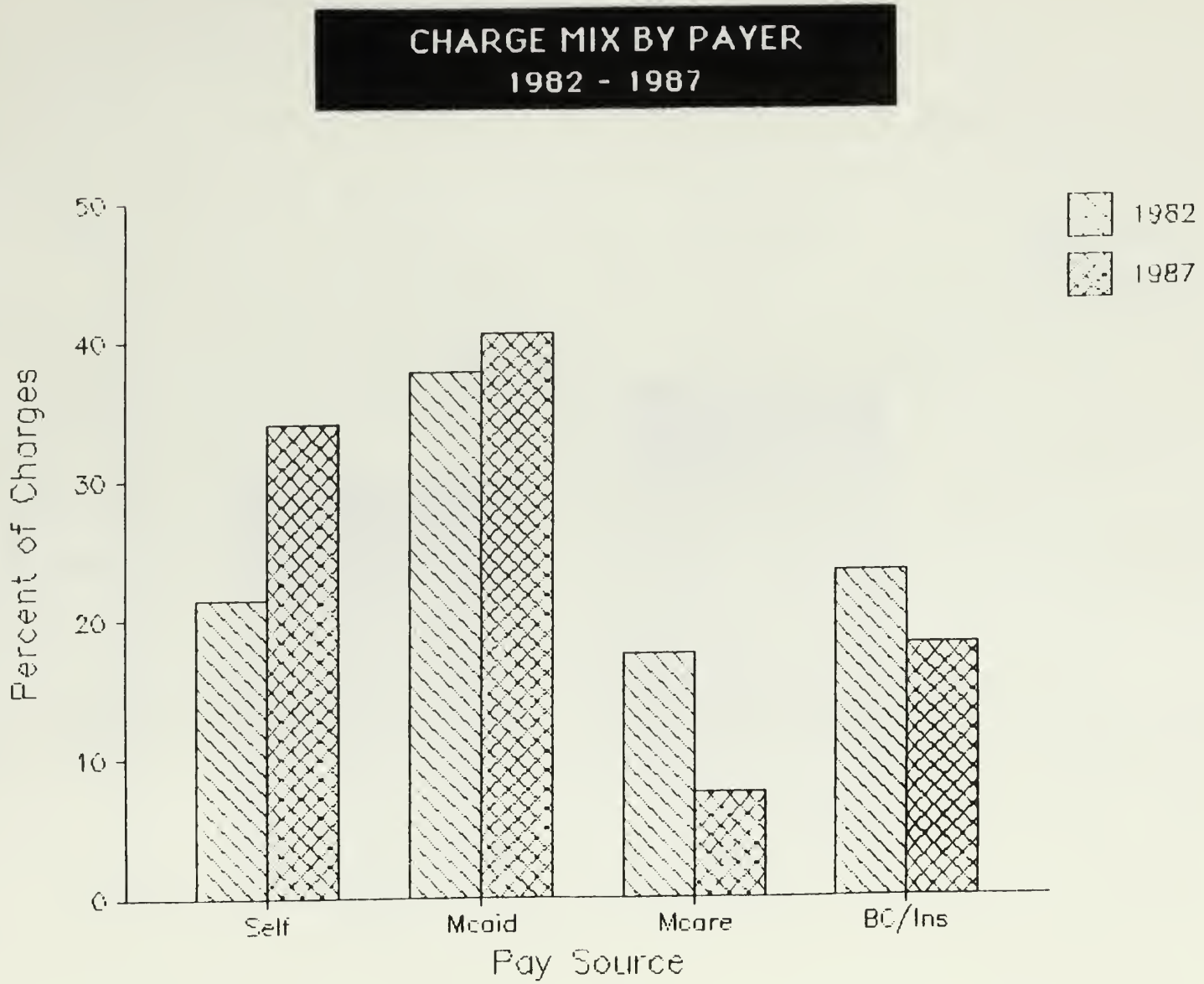

CHARGE MIX BY PAYER
1982 - 1987
1982
1987
Percent of Charges
50
40
30
20
10
0
Self
Medicaid
Medicare
BC/Ins
Pay Source

FIGURE 5

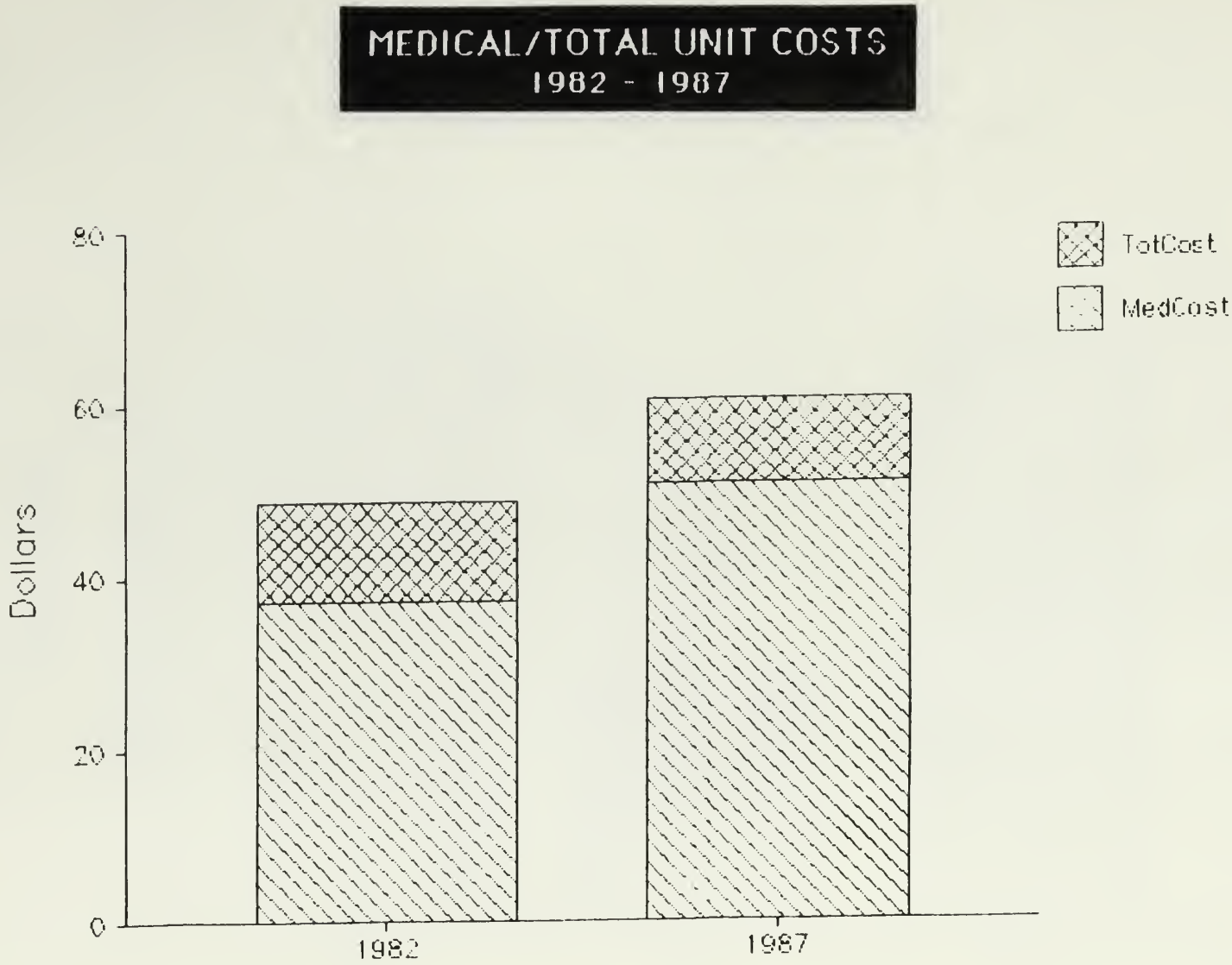

MEDICAL/TOTAL UNIT COSTS
1982 - 1987
Dollars
80
60
40
20
0
1982
1987
TotCost
MedCost

FIGURE 6

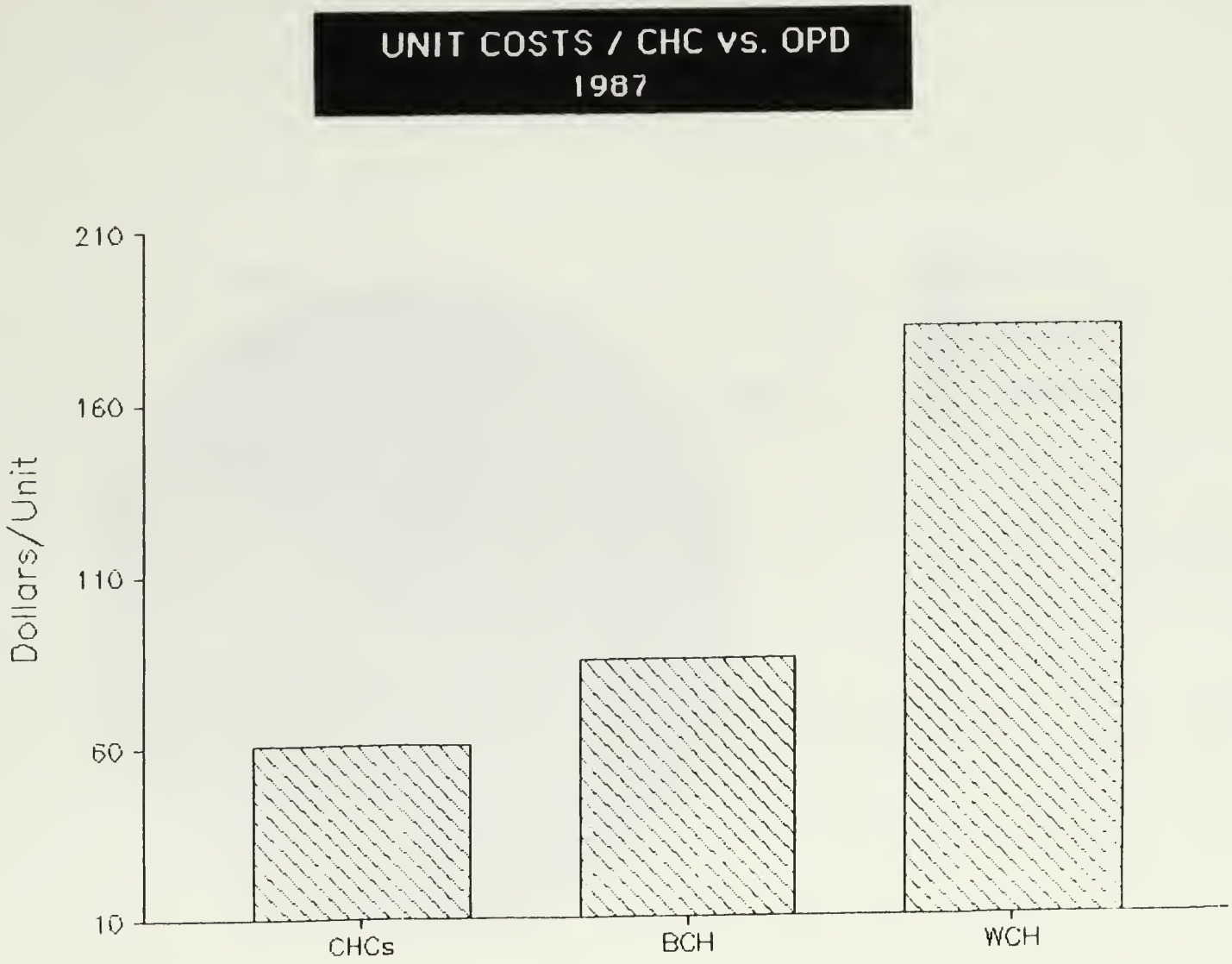

UNIT COSTS / CHC vs. OPD
1987
Dollars/Unit
210
160
110
60
10
CHCs
BCH
WCH

FIGURE 7a

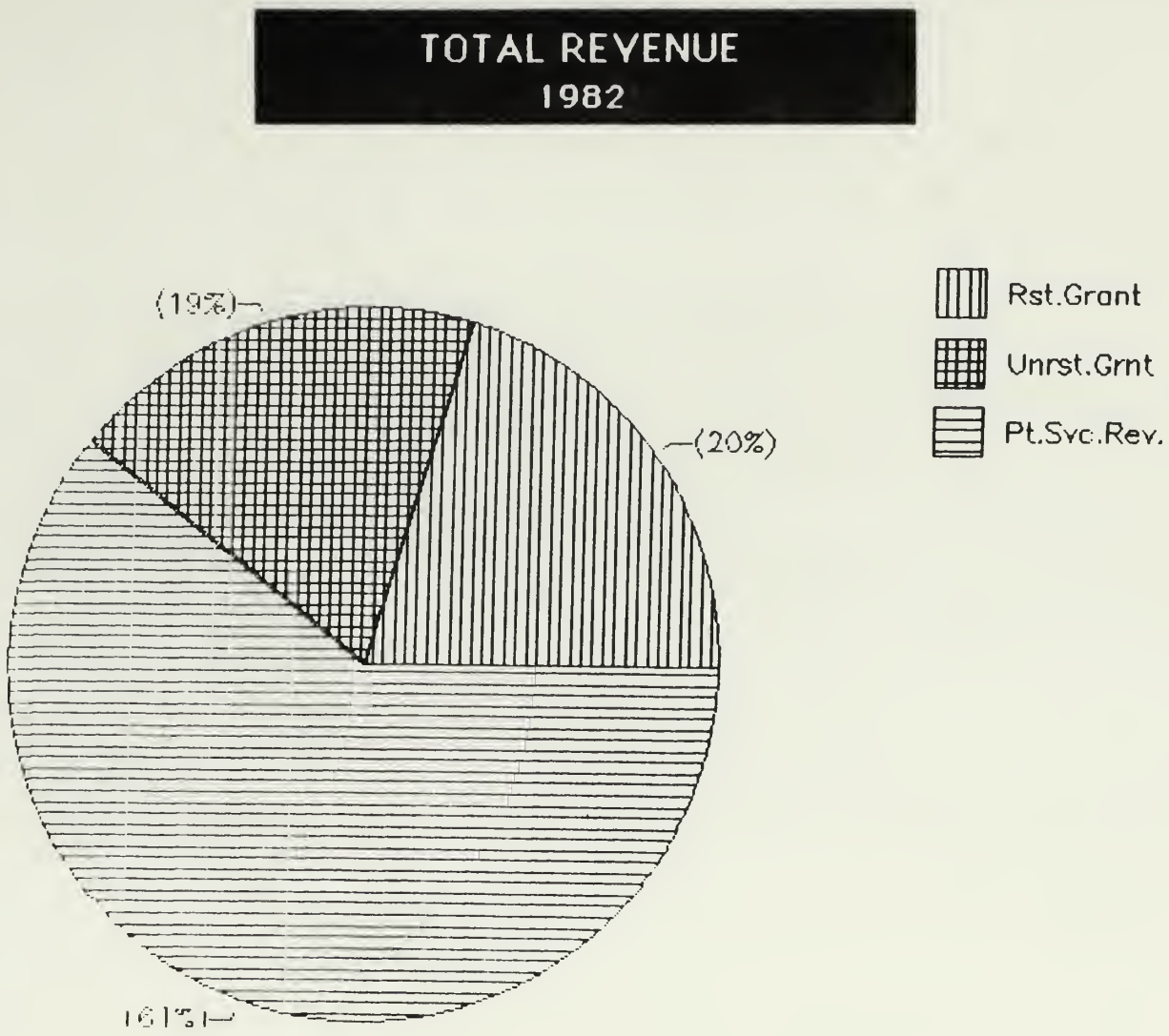


FIGURE 7b

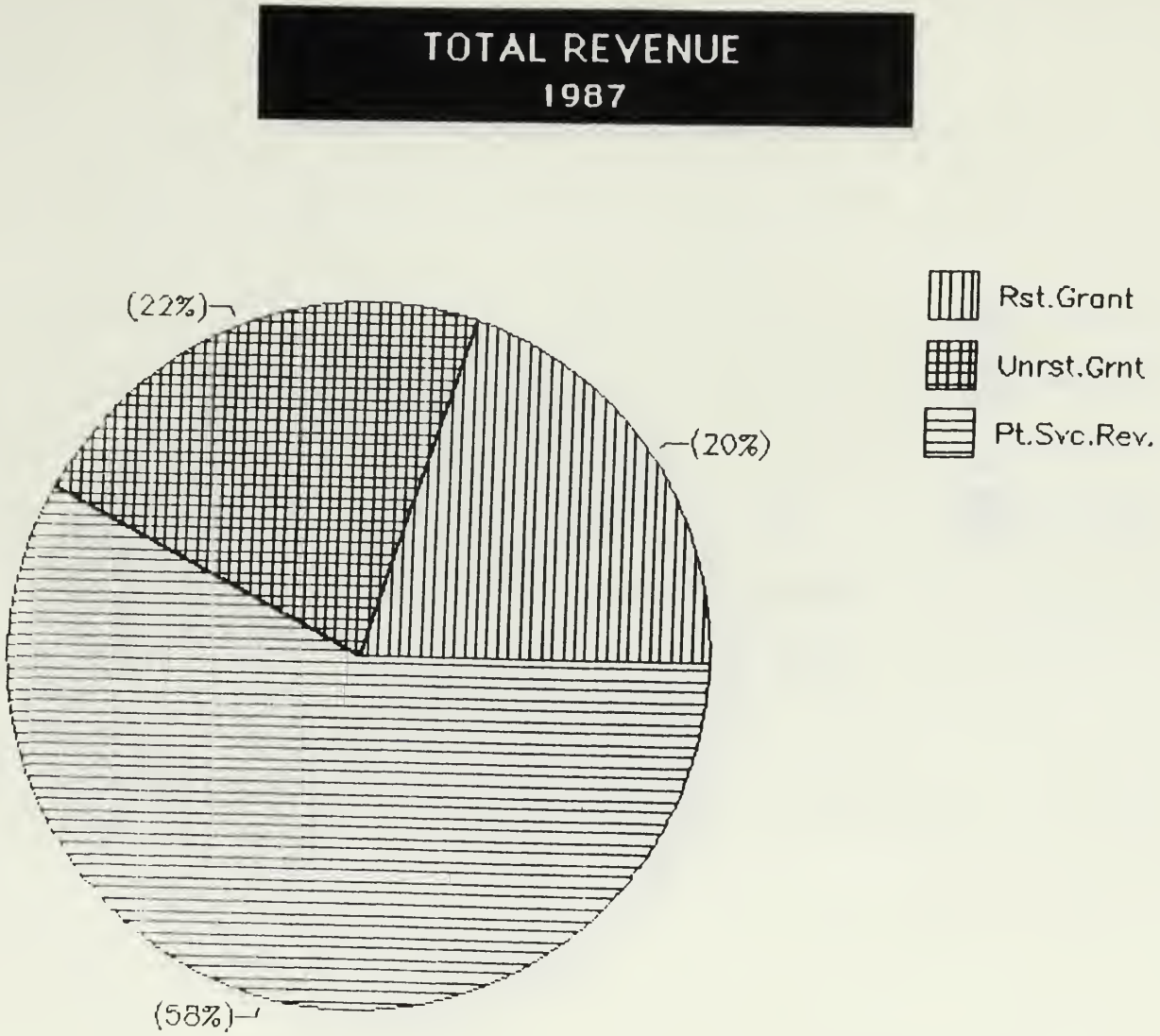


FIGURE 8a

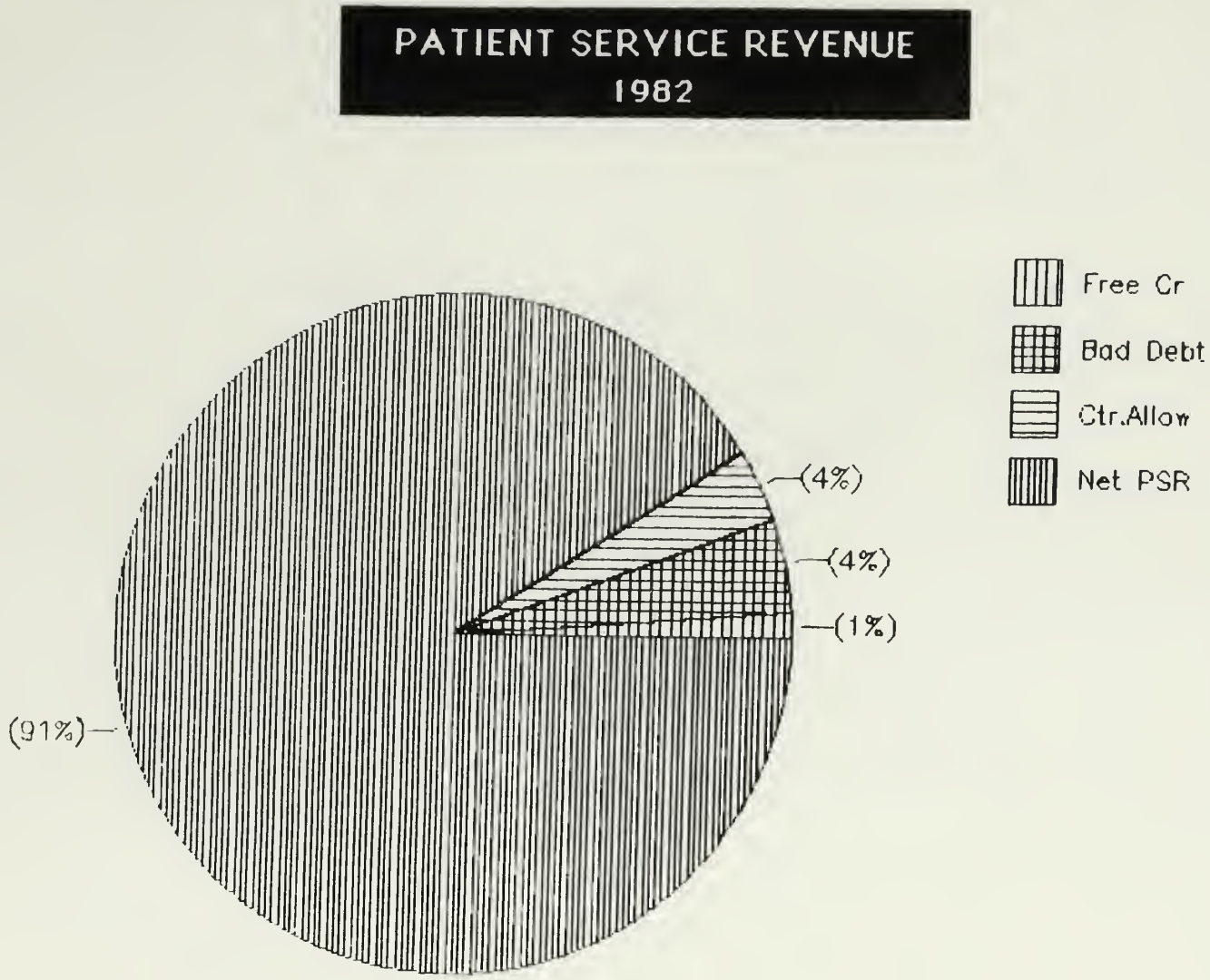
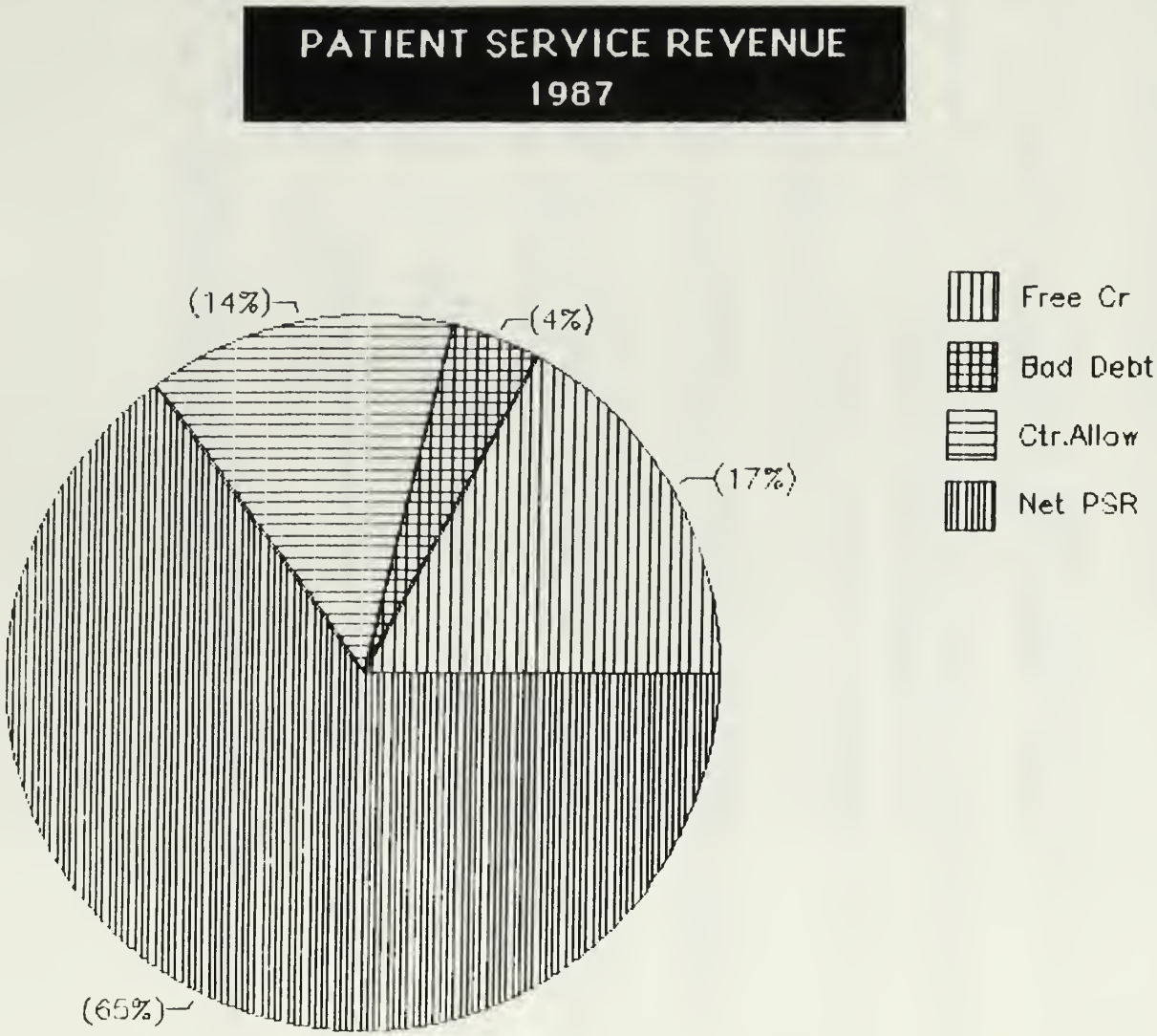

PATIENT SERVICE REVENUE
1982
(4%)
(4%)
(1%)
(91%)
Free Cr
Bad Debt
Ctr.Allow
Net PSR

FIGURE 8b


PATIENT SERVICE REVENUE
1987
(14%)
(4%)
(17%)
(65%)
Free Cr
Bad Debt
Ctr.Allow
Net PSR

APPENDIX B: REFERENCES

Anderson, Elizabeth J. et al. The Neighborhood Health Center Program, Its Growth and Problems: An Introduction. Washington, D.C.: National Association of Neighborhood Health Centers, Inc., 1976.

Freeman, H.E. et al. "Community Health Centers: An Initiative of Enduring Utility," Milbank Memorial Fund Quarterly 60(2): 245- 67.

Ginzberg, Eli et al. "The Community Health Center: Current Status and Future Directions," Journal of Health Politics, Policy, and Law 10(2): 283-98.

May, Jude Thomas. "The Professionalization of Neighborhood Health Centers," Health/PAC Bulletin 12(2): 1-2,6-9.

Plough, Alonzo, Holly Korda, and Thomas DelBanco. Boston At Risk - a Report from The Boston Foundation Primary Health Care Seminar, September, 1985.

Reynolds, Roger A. "Improving Access to Health Care Among the Poor - The Neighborhood Health Center Experience," Milbank Memorial Fund Quarterly/Health and Society 54(1): 47-81.

Sardell, Alice. "The Neighborhood Health Center: Model and Federal Policy," Health PAC Bulletin 12(2): 10, 19-21, 27.

Strelnick, Hal. "Expanding Sutton's Law," Health/PAC Bulletin 12 (November/December, 1980): 22-26.

Young, Dale. A Promise Kept: Boston's Neighborhood Health Centers. Boston: Trustees of Health and Hospitals, 1982.

Design and layout by
Harry O Lohr, Jr., Director
Office of Communications

Massachusetts Rate Setting Commission
Two Boylston Street
Boston, Massachusetts 02116

(617) 451-5330

Approved by Ric Murphy, State Purchasing Agent
Publication Number: 15,795-36pgs-150cps-1-11-89